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No. 06-1356

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SUPREME COURT, U.S.

IN THE

Supreme Court of the United States

JEANETTE ROGERS DULAN,

Petitioner,

v.

HUNTSVILLE HOSPITAL and
CHRIS ANDERSHOCK, M.D.,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

BRIEF IN OPPOSITION

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QUESTIONS PRESENTED

I. Whether the District Court was bound, under the doctrine of collateral estoppel, by the Centers for Medicare and Medicaid Services' preliminary conclusion that Huntsville Hospital violated the Emergency Medical Treatment and Labor Act, 42 U.S.C. § 1395dd, *et seq.* ("EMTALA"), when the preliminary conclusion was reached without a hearing and was later withdrawn.

II. Whether the District Court correctly applied Alabama law in entering a summary judgment for Respondents on Petitioner's state law claims for medical malpractice due to her failure to present the testimony of a qualified expert to establish the standard of care, a breach of the standard of care, and proximate cause.

III. Whether the District Court abused its discretion in striking Petitioner's designation of a medical expert for failure to comply with the scheduling order entered by the court.

LIST OF PARTIES

There are no parties to the proceedings other than those listed in the caption.

"Huntsville Hospital Association, Inc." does not exist. Huntsville Hospital is a public, non-profit hospital owned and operated by The Health Care Authority of the City of Huntsville, Alabama. The Health Care Authority is a public, non-profit corporation organized under the authority of the City of Huntsville pursuant to Alabama's Health Care Authorities Act of 1982, Ala. Code § 22-21-310, *et seq.* (1975).

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STATEMENT OF THE CASE

This case involves Alabama state law claims for medical malpractice, and claims under the Emergency Medical Treatment and Labor Act, 42 U.S.C. § 1395dd, *et seq.* ("EMTALA"). The Petitioner, Dulan, claimed that Huntsville Hospital violated § 1395dd(a) of EMTALA by failing to provide her an appropriate medical screening examination, and that the Hospital violated § 1395dd(h) by delaying treatment to inquire about her method of payment or insurance status. (Doc. 1, Count I). Dulan also asserted medical malpractice claims against the Hospital and Dr. Chris Andershock, an emergency physician employed by the Hospital. (Doc., Counts II - VI). Finally, although her petition does not directly address this claim, Dulan asserted a claim against Dr. Andershock under 42 U.S.C. § 1981 based on allegations that Dr. Andershock (a white male) discriminated against Dulan (a black female) on the basis of race. (Doc. 1, Count VII). The District Court entered a summary judgment for the Hospital and Dr. Andershock on all claims. (Doc. 107). The memorandum opinion accompanying the judgment is unpublished. The Eleventh Circuit affirmed the judgment, without opinion.

A. Dulan's medical care.

Huntsville Hospital is the primary trauma center for northern Alabama, and the Hospital's emergency department is the busiest in the state. (*Id.*). Jeanette Dulan's mother drove her to the emergency room at the Hospital on the afternoon of October 6, 2000, after Dulan began experiencing chest pain during a visit to her parents' home in Huntsville. (Depo. of Jeanette Dulan, Doc. 82, Exhibit A, pp. 73-74, 78). According to the emergency department record of

Dulan's visit, she arrived at the emergency room at 1:02 p.m. (Emergency Department Record, Exhibit O to Doc. 84). Based on their recollection, Dulan and her mother believe they arrived at the ER at approximately 12:30 p.m. (Dulan depo., Doc. 82, Exhibit A, pp. 84-85; Depo. of Mildred Rogers, Doc. 82, Exhibit B, pp. 27, 34).

Dulan testified that, when her car arrived at the emergency room entrance, a Hospital employee immediately brought a wheelchair to the car and wheeled Dulan to a counter inside the ER. (Dulan depo., Doc. 82, Exhibit A, pp. 80-81). The desk nurse at the counter handed Dulan a clipboard and asked her to complete a short "half pass" form. (Dulan depo., Doc. 82, Exhibit A, pp. 81, 85-86). The initial registration form is referred to by Hospital personnel as a "half pass" because it is used to complete a partial "pass" through the computer system in order to quickly open a chart, create a wristband for the patient, and generate a patient record number. (Affidavit of Wanda Della-Calce, Doc. 82, Exhibit F, p. 1).

The "half pass" form requested several types of basic information, including name, address, Social Security number, gender, marital status, and primary insurance carrier. (Della-Calce affidavit, Doc. 82, Exhibit F, p. 1). The only information Dulan provided on the form was her name and address, which took her "a few seconds." (Dulan depo., Doc. 82, Exhibit A, pp. 81, 85-86). Based on the information Dulan gave the desk nurse concerning her complaints and symptoms, the desk nurse categorized Dulan as "Priority 2," which meant that Dulan did not need immediate care but should receive care as soon as possible. (Affidavit of Kim Lundy Clanton, Doc. 82, Exhibit G, p. 1). Dulan's mother arrived at the counter and wheeled Dulan to the waiting room. (Dulan depo., Doc. 82, Exhibit A, pp. 86-87).

A triage nurse assessed Dulan in the triage area and obtained a history at 1:10 p.m. (Emergency Department Record, Doc. 84, Exhibit O, p. 1). The triage nurse had no information about Dulan's insurance status. (Clanton affidavit, Doc. 82, Exhibit G, p. 2). The only information the triage nurse had before undertaking her assessment of Dulan was Dulan's name and age and the fact that the desk nurse had categorized Dulan as a Priority 2 patient. (*Id.*). Following her own assessment of Dulan, the triage nurse also determined that Dulan was Priority 2. (*Id.*, p. 1).

The ER's policy and practice was to move Priority 2 patients to a bed in the ER as soon as possible. (Clanton affidavit, Doc. 82, Exhibit G, p. 1). If a bed was not immediately available, the policy allowed a Priority 2 patient to be sent back to the waiting room until a bed became available. (*Id.*). When the triage nurse completed her assessment of Dulan, there was no bed immediately available. (*Id.* at p. 2). Dr. Chris Andershock, the emergency physician who treated Dulan, testified that the emergency room was "very busy" at the time of Dulan's visit, and that he worked longer than his normal shift that day due to the number of patients. (Depo. of Dr. Andershock, Doc. 82, Exhibit C, pp. 10, 74).

Upon completing her assessment of Dulan, the triage nurse alerted the ER charge nurse, Shari Duke, that a bed was needed for a Priority 2 patient. (Clanton affidavit, Doc. 82, Exhibit G, p. 1; Affidavit of Shari Duke, Doc. 82, Exhibit H, p. 1). Nurse Duke, who also had no information about Dulan's insurance status, immediately began attempting to secure a bed for Dulan. (Duke affidavit, Doc. 82, Exhibit H, pp. 1,3). Because all of the ER's dedicated cardiac care rooms were in use, Duke arranged for

Dulan to be placed in another bed appropriate for care of a patient with a possible myocardial infarction. (Duke affidavit, Doc. 82, Exhibit H, p. 1).

According to Dulan, once the triage nurse completed her assessment, the nurse told Dulan, "Wait in the waiting room, someone will call you." (Dulan depo., Doc. 82, Exhibit A, pp. 101-102). Dulan's mother then wheeled her back to the waiting room. (*Id.*, pp. 102-103). Shortly after Dulan returned to the waiting room, a clerk called her to a counter and asked for personal information such as address, name of employer, and insurance information. (*Id.*). According to the registration clerk, she called Dulan to the counter to obtain registration information because Dulan was available in the waiting room. (Affidavit of Regina Lewis Mohler, Doc. 82, Exhibit I, p. 1). The clerk did not interrupt any aspect of Dulan's care, including any examinations or treatment, to obtain registration information. (*Id.*, pp. 1-2; Clanton affidavit, Doc. 82, Exhibit G, p. 2).

Dulan gave the registration clerk the name of her insurance company, but Dulan did not have an insurance card. (Dulan depo., Doc. 82, Exhibit A, pp. 103-104). The only information the registration clerk obtained from Dulan was her name, address, and emergency telephone numbers. (Mohler affidavit, Doc. 82, Exhibit I, p. 2). Dulan testified that she spoke with the registration clerk for "not more than five minutes." (Dulan depo., Doc. 82, Exhibit A, pp. 106-107). According to the Hospital's computer records, Dulan interacted with the registration clerk from 1:31 p.m. to 1:33 p.m. (Mohler affidavit, Doc. 82, Exhibit I, p. 2).

After arranging a bed for Dulan, Charge Nurse Duke went to the waiting room to retrieve Dulan, and found her at

a counter talking with the registration clerk. (Duke affidavit, Doc. 82, Exhibit H, p. 1). Duke confirmed that Dulan was still having chest pains, and then immediately took her into the treatment area. (*Id.*, pp. 1-2; Dulan depo., Doc. 82, Exhibit A, pp. 106-108). Dulan told the registration clerk that her mother could provide any further information needed by the clerk. (Dulan depo., Doc. 82, Exhibit A, pp. 111-112). Dulan's mother remained at the counter to attempt to provide further information, which took "about five minutes." (Mildred Rogers depo., Doc. 82, Exhibit B, pp. 43-48; Mohler affidavit, Doc. 82, Exhibit I, p. 2). This was the last inquiry about insurance on that day (Dulan depo., Doc. 82, Exhibit A, p. 114), and no attempt was made that day to verify that Dulan was actually insured. (Mohler affidavit, Doc. 82, Exhibit I, p. 2). All examinations and treatment the Hospital provided to Dulan on October 6, 2000 were provided without any verification that she had insurance. (Dulan depo., Doc. 82, Exhibit A, p. 111).

Although all regular cardiac care rooms were in use when Nurse Duke took Dulan into the ER's treatment area, Duke still was able to place Dulan on cardiac monitoring, pulse oximetry, and blood pressure monitoring equipment as soon as Dulan was placed on the bed Duke had arranged. (Duke affidavit, Doc. 82, Exhibit H, p. 2). This monitoring equipment was in place by 1:35 p.m., 33 minutes after Dulan's arrival at the emergency room according to the emergency department record. (*Id.*). Duke also initiated a "cardiac battery" by performing an ECG, which was completed at 1:38 p.m. (*Id.*). A chest x-ray was performed at 2:05 p.m. (*Id.*). After two unsuccessful attempts to gain IV access, Duke requested the assistance of another nurse, who obtained IV access at 2:15 p.m. (*Id.*). Blood was drawn at 2:20 p.m. to be tested for cardiac enzymes, a complete blood

count, a basic metabolic profile, and any other tests order by the emergency physician. (*Id.*).

From the time Dulan was brought into the treatment area by Nurse Duke, Dulan was continuously connected to the appropriate monitoring equipment and was kept in the immediate vicinity of the nurse's station for close observation. (Duke affidavit, Doc. 82, Exhibit H, p. 2). Duke testified that she was familiar with the Hospital's nursing guidelines for patients with chest pain suggesting myocardial infarction, and that she fully complied with the guidelines. (*Id.*). Duke followed Hospital routine and the nursing guidelines by placing Dulan's chart in a rack along with the ER nurse's notes, so that the emergency physician would have this information available when deciding what tests should be ordered. (*Id*).

A nurse again took Dulan's vital signs at 2:30 p.m. (Emergency Department Record, Doc. 84, Exhibit O, p. 1). At 2:40 p.m., Dulan was examined by an emergency physician, Dr. Andershock. (Depo. of Dr. Chris Andershock, Doc. 82, Exhibit C, pp. 7, 9-10, 12). Dr. Andershock took a history, performed a physical examination, and assessed Dulan. (Emergency Physician Record, Doc. 84, Exhibit O). Dulan's vital signs were taken at 2:50 p.m., and she was given two baby aspirin, one sublingual nitroglycerin, and one inch of nitroglycerin paste. (Emergency Department Record, Doc. 84, Exhibit O). At 3:05 p.m., Dulan was given potassium chloride. (*Id.*). A nurse again took Dulan's vital signs and performed an assessment at 3:20 p.m., assessed her again at 3:35 p.m., and informed Dr. Andershock of Dulan's condition. (*Id.*).

The cardiac patient who had been occupying cardiac bed 10 in the ER was admitted to the Hospital at 3:35 p.m., and Dulan was moved into room 10 at 3:43 p.m. (Emergency Department Record, Doc. 84, Exhibit O; Duke affidavit, Doc. 82, Exhibit H, p. 2). Dulan's bilateral blood pressure was taken and her heart rate was checked at 3:43 p.m. (Emergency Department Record, Doc. 84, Exhibit O). Dr. Andershock ordered that Dulan be given two milligrams of morphine, and this was done at 3:53 p.m. (*Id.*). At 4:20 p.m., Dulan was given another three milligrams of morphine, her blood pressure and vital signs were again taken, and the pulse oximeter was checked. (*Id.*). A nurse again checked Dulan's vital signs at 4:30 p.m. and also assessed her at 4:50 p.m. and 5:15 p.m. (*Id.*).

Dulan remained under Dr. Andershock's care until approximately 5:15 p.m., when she was examined by a cardiologist's assistant at Dr. Andershock's request. (Andershock depo., Doc. 82, Exhibit C, pp. 12, 28-30, 95). Dulan was admitted to the Hospital's cardiac care unit ("CCU") at 5:40 p.m. in accordance with the cardiologist's orders. (Physician's Orders, Doc. 84, Exhibit O). The admission was for further care and treatment and to "[r]ule out myocardial infarction." (History and Physical signed by Dr. Carl Gessler, Doc. 84, Exhibit O). Dulan continued to be monitored and treated in the ER under the cardiologist's supervision until she was physically transferred to the CCU at 7:15 p.m. (Physician's Orders, Doc. 84, Exhibit O).

The cardiologist's first handwritten note concerning Dulan questioned whether she had a myocardial infarction or pericariditis. (Progress Notes of Dr. Gessler, Doc. 84, Exhibit O). A second ECG was performed in the CCU at 7:54 p.m., and the cardiologist then noted: "Not clear cut

[therefore] defer [thrombolytics] until [catheterization]." (*Id.*). Another cardiologist stated in Dulan's discharge summary that this ECG "was consistent both with myocardial infarction as well as pericariditis." (Discharge Summary signed by Dr. Henry Chen, Doc. 84, Exhibit O). Later during the night of October 6, 2000, Dulan underwent a cardiac catheterization which showed that she was suffering an anterior myocardial infarction. (Cardiac Catheterization Report, Doc. 84, Exhibit O). Dr. Andershock testified that Dulan was not suffering from myocardial infarction when she arrived in the ER. (Andershock depo., Doc. 82, Exhibit C, p. 16).

Dr. Andershock testified that the Hospital's standard medical screening exam for all emergency room patients was to "triage the patient to determine the priority of the patient's need for treatment, obtain a history and physical concerning the patient's problem, and perform a physical examination related to the patient's problem." (Affidavit of Dr. Andershock, Doc. 82, Exhibit D, p. 1). For patients who complained of chest pains suggesting a myocardial infarction, the standard screening exam also called for "a cardiac battery consisting of electrocardiogram, chest x-ray, cardiac enzymes, a complete blood count, and a basic metabolic profile." (*Id.*). Dulan's ECG was completed at 1:38 p.m., her chest x-ray was performed at 2:05 p.m., and blood was drawn at 2:20 p.m. for a complete blood count, cardiac enzymes, and a basic metabolic profile. (Duke affidavit, Doc. 82, Exhibit H, p. 2). Dr. Andershock completed the history and examination at 2:40 p.m., at which time he checked the box on the Emergency Physician Record indicating that Dulan was to be "admitted." (Emergency Physician Record, Doc. 84, Exhibit O).

A cardiac catheterization procedure is not a component of the Hospital's standard screening examination for patients who present with chest pain. (Affidavit of Dr. Andershock, Doc. 82, Exhibit D, p. 1). The decision to perform a cardiac catheterization is made by the patient's cardiologist, and not by emergency room physicians or nurses. (*Id.*). As an ER physician, Dr. Andershock did not have privileges to order or perform a cardiac catheterization. (*Id.*).

Dr. Andershock testified that the practice at the Hospital's ER was "to bring patients with chest pain back as soon as possible, and that has been my personal experience that they bring them back as quickly as they physically can find a place for them." (Andershock depo., Doc. 82, Exhibit C, p. 74). According to Dr. Andershock, Dulan received care as soon as possible, and the screening exam she received was appropriate and was the same screening provided to other patients with similar symptoms. (*Id.*, pp. 31, 128-129). In Dr. Andershock's opinion, the care and treatment provided to Dulan met the applicable medical standard of care. (*Id.*, p. 128).

Dr. Marlon Priest, a board certified emergency physician who is medical director of the emergency department at UAB Hospital in Birmingham, also provided his opinion that Dulan received an appropriate medical screening that was calculated to identify critical medical conditions and was adequate to identify Dulan's condition. (Affidavit of Dr. Marlon Priest, Doc. 82, Exhibit J, p. 1). Dr. Priest also testified that the care provided to Dulan met the required standard of care. (*Id.*). Dulan presented no expert testimony concerning the standard of care or the adequacy of the medical screening exam.

In connection with Dulan's discrimination claim under § 1981, the District Court ordered the Hospital to respond to an interrogatory propounded by Dulan by compiling statistical information concerning examinations and treatment provided to ER patients. (Doc. 56). The Hospital gathered the data for the statistical analysis in conformity with the request of Dulan's attorney. (Affidavit of Elizabeth Scrivens, Doc. 82, Exhibit J, p. 1; Affidavit of Jerry Smith, Doc. 82, Exhibit L, p. 1). Dr. George Howard, Chairman of the Department of Biostatistics at the University of Alabama at Birmingham, randomly selected the patient records to obtain the data requested by Dulan. (6/14/04 depo. of George Howard, Doc. 83, Exhibit M, p. 80). In Dr. Howard's opinion, Dulan's data request caused the data to be biased in favor of her contentions. (Howard Report, attached to 6/29/04 Howard depo. as Exhibit 6, Doc. 83, Exhibit N, pp. 3-4, 15, 16). Nonetheless, the data compilation requested by Dulan revealed that she received the same tests and treatment as the average white patient, and received them faster. (Attachment C to Affidavit of Jerry Smith, Doc. 82, Exhibit 2). Although Dulan's statistical expert gave her opinion that the data showed that white patients were more likely to receive aspirin, Dulan herself was given aspirin. (*Id.*).

B. The CMS proceeding.

Dulan argued in the District Court that the court was bound, under the doctrine of collateral estoppel, by a preliminary conclusion by the Centers for Medicare and Medicaid Services ("CMS") that the Hospital violated EMTALA by inquiring about insurance before Dulan's medical screening examination was completed. (Doc. 73). Dulan filed a complaint with CMS in June of 2003, and a surveyor employed by the State of Alabama performed a

survey at the Hospital that same month. (Doc. 96, Ex. 1). After a delay of over one year, CMS notified the Hospital on August 10, 2004 that the agency had determined that the Hospital violated 42 C.F.R. § 489.24, CMS's regulation pertaining to EMTALA, through a "[f]ailure to avoid delay in providing a medical screening exam in order to inquire about the individual's method of payment or insurance status for an individual who came to the Hospital requesting services." (*Id.*). Based on this preliminary determination, CMS intended to "terminate Huntsville Hospital's participation in the Medicare program." (*Id.*).

The letter from CMS informed the Hospital that "this *preliminary* determination letter serves to notify you of the violation." (*Id.*) (emphasis added). The letter stated that the Hospital would receive a "termination letter" on August 29, 2004, which would be the "*final* notice" of termination. (*Id.*) (emphasis added). CMS further stated in its letter that, if it verified corrective action by the Hospital or determined that the Hospital had successfully refuted the findings contained in the letter, the Hospital's termination from the Medicare program would be "rescinded." (*Id.*) (emphasis added).

In response to the letter from CMS, the Hospital presented a plan of correction to CMS, and also presented a written submission supporting the Hospital's position that no EMTALA violation occurred. (Affidavit of Robbin McCord, Doc. 77, Exhibit A). CMS declined to accept the written submission. (*Id.*). In a letter dated August 26, 2004, however, CMS informed the Hospital that the Hospital's plan of correction "adequately addressed the cited deficiencies." (Doc. 96, Exhibit 2). Based on that documentation, verified by a "follow-up survey," CMS informed the Hospital that it

was "*withdrawing* the termination action as stated in the previous correspondence." (*Id.*).

The District Court declined to give collateral estoppel effect to CMS's preliminary conclusion that the Hospital violated EMTALA. (Doc. 87). The court stated:

> After considering all of the evidence and arguments presented by parties, it is clear to the court that there was no final decision by the administrative agency. There was an initial investigation by the agency along with a preliminary finding, but no final decision. In addition, there was a lack of an opportunity to litigate the issues before the administrative agency, as well as a complete absence of actual litigation.

(Doc. 73).

The District Court entered a summary judgment for the Hospital and Dr. Andershock on all claims. In an unpublished memorandum opinion accompanying the order granting summary judgment, the court noted Dulan's argument that "CMS's conclusion that the Hospital 'failed to avoid delay in providing a medical screening exam in order to inquire about the individual's method of payment or insurance status,' creates an issue of material fact in her favor." (Doc. 106, pp. 14-15). In rejecting CMS's conclusion as "not evidence or helpful in this instance," the court noted that CMS had preliminarily concluded there was an EMTALA violation because the Hospital did not provide Dulan a screening exam before inquiring about insurance. (*Id.*). The court observed that this was "not the appropriate legal

standard for assessing a violation of § 1395dd(h) of EMTALA," because federal regulations permit hospitals to inquire about insurance as long as the inquiry does not delay medical screening or treatment. (*Id.* at pp. 14-15). The District Court concluded that Dulan presented no evidence to support her claim that the Hospital failed to provide her an appropriate medical screening exam, that the screening exam was delayed by any inquiry about insurance, or that Dulan suffered any personal harm as a result of any alleged delay. (*Id.* at pp. 10-15).

C. The exclusion of Dulan's expert.

With regard to the claim for medical malpractice, the District Court observed in its memorandum opinion that Alabama law requires plaintiffs asserting such claims to present the testimony of a qualified medical expert to establish the standard of care, a breach of the standard of care, and proximate cause. (Doc. 106, p. 20). Dulan failed to produce any such testimony. (*Id.*). Dulan designated a cardiologist to provide expert testimony, but the court struck the designation of the expert for failure to comply with the requirements of the court's scheduling order. (Doc. 40).

REASONS FOR DENYING THE PETITION

I. Introduction.

Dulan contends the Court should grant certiorari to review a summary judgment which the District Court entered without publishing an opinion, and which the Eleventh Circuit affirmed without opinion. There is no decision here that states any rule of law that conflicts with the decisions of other circuits or of this Court. Dulan claims the District Court misapplied or failed to follow certain decisions of this Court and the Alabama Supreme Court, but her argument is based on a misstatement of the facts and, in some instances, a misunderstanding as to what law even applies. In any event, all of the questions raised by Dulan are moot because the respondents were entitled to a summary judgment for other reasons unrelated to the issues presented here. There is no conceivable basis for granting certiorari.

II. The agency's preliminary conclusion that EMTALA was violated was not binding on the court in Dulan's EMTALA action, for several independent reasons.

Dulan contends that, in refusing to give collateral estoppel effect to the preliminary conclusion by CMS that Huntsville Hospital violated EMTALA, the court misapplied *University of Tennessee v. Elliott*, 478 U.S. 788, 106 S.Ct. 3220, 92 L.Ed.2d 635 (1986). The Court in *Elliott* recognized, as it had previously in *U.S. v. Utah Construction and Mining Co.*, 384 U.S. 394, 86 S.Ct. 1545, 16 L.Ed.2d 642 (1966), that there are circumstances where an administrative agency's findings of fact should be given preclusive effect under the doctrine of collateral estoppel or issue preclusion. The District Court here correctly determined that the preliminary conclusion by CMS was not binding on the court, for multiple reasons.

The Court in *Utah Construction* stated that collateral estoppel may apply "[w]hen an administrative agency is acting in a judicial capacity and resolved disputed issues of fact properly before it which the parties have had an adequate opportunity to litigate." 87 S.Ct. at 1550. Citing *Utah Construction*, the Eleventh Circuit stated the requirements for applying collateral estoppel to an administrative decision in *Pantex Towing Corp. v. Glidewell*, 763 F.2d 1241 (11th Cir. 1985). The court stated:

> Issues of fact litigated and decided in a prior administrative proceeding may have collateral estoppel effect on issues of fact presented in a subsequent judicial action. The parties agree that when an administrative body has *acted in a judicial capacity* and has issued a valid and *final* decision on *disputed issues of fact* properly before it, collateral estoppel will apply to preclude relitigation of fact issues *only if*: (1) there is identity of the parties or their privies; (2) there is *identity of issues*; (3) the parties had an *adequate opportunity to litigate* the issues in the administrative proceeding; (4) the issues to be estopped were *actually litigated and determined* in the administrative proceeding; and (5) the findings on the issues to be estopped were necessary to the administrative decision.

763 F.2d at 1245 (emphasis added).

Several of the requirements for applying collateral estoppel obviously are not satisfied here. First, when deciding whether an administrative decision is entitled to preclusive effect, the question whether the five standard collateral

estoppel requirements are satisfied does not even arise unless the administrative body "acted in a judicial capacity" and "issued a valid and final decision." *Pantex Towing*, 763 F.2d at 1245. The preliminary finding by CMS does not even come close to clearing this initial hurdle.

CMS determined, based only on a survey, that the Hospital had violated EMTALA, and CMS notified the Hospital of this determination in a "*preliminary* determination letter." (Doc. 97, Ex. 1) (emphasis added). The letter stated that the Hospital would soon receive a "termination letter," which would be the "*final* notice" of termination of the Hospital's participation in the Medicare program. (*Id.*) (emphasis added). This was in accordance with 42 C.F.R. § 489.53(c), which provides for a "preliminary" notice of termination, followed by a "final" notice if the agency determines that the termination should go forward. CMS further stated in its letter that, if it verified corrective action by the Hospital or determined that the Hospital had successfully refuted the findings contained in the letter, the Hospital's termination from the Medicare program would be "rescinded." (*Id.*).

In a subsequent letter, CMS informed the Hospital that it had received documentation that "adequately addressed the cited deficiencies." (Doc. 96, Ex. 2). Based on that documentation and a second survey, CMS informed the Hospital that it was "*withdrawing* the termination action." (*Id.*) (emphasis added). There was never any final determination by CMS, or any other agency, that Huntsville Hospital violated EMTALA.

Dulan's assertion that CMS made "findings" that were "final," "uncontested," and "unappealed" is wrong on all counts. First, the letters from CMS actually contained *no* factual findings, but instead discussed CMS's *legal conclusion* that the Hospital violated an EMTALA regulation. Second, CMS's conclusion was self-described as "preliminary," and the termination action was later withdrawn. Third, the Hospital contested the preliminary conclusion and presented evidence in support of its position, but CMS elected to withdraw the termination action based on the Hospital's plan of correction. Finally, while it is technically correct that the preliminary conclusion was "unappealed," this is only because the conclusion was non-appealable. The Hospital's right to a hearing, and to administrative and judicial review, would have arisen only if CMS had given a final notice of termination. *See* 42 C.F.R. § 498.5.

Since it is clear that CMS did not act in a judicial capacity in concluding there was an EMTALA violation, and its preliminary conclusion was not a final decision in any event, it was unnecessary for the District Court even to determine whether the standard requirements for collateral estoppel were otherwise satisfied. Nevertheless, it is clear those requirements were *not* satisfied. First, collateral estoppel requires that there be an "identity of issues," *Pantex Towing*, 736 F.2d at 1246, and the issue before CMS was not the same issue presented by Dulan's EMTALA claim.

As the District Court pointed out, CMS applied an incorrect legal standard in concluding that EMTALA was violated. EMTALA does not forbid inquiries about insurance before the medical screening examination is completed, so long as no examination or treatment is delayed by the inquiry. *See* § 1395dd(h) ("Hospitals may follow reasonable registration processes . . . , including asking whether an individual is insured and, if so, what that insurance is, as long as that inquiry does not delay screening or treatment."). CMS's own regulation recognizes this. *See* 42 C.F.R. § 489.24(d)(4)(iv). Even aside

from the fact, CMS made no finding that the alleged EMTALA vioation resulted in any injury. Under 42 U.S.C. § 1395dd(d)(2)(A), a private right of action under EMTALA is available to an individual only if she "suffers personal harm as a direct result of a participating hospital's violation of a requirement [under EMTALA]." Whether Dulan was injured by a violation of EMTALA was not even an issue for CMS.

Collateral estoppel also requires that the parties "had an adequate opportunity to litigate the issues in the administrative proceeding." *Pantex Towing*, 763 F.2d at 1245. This is the most obvious reason why collateral estoppel could not be applied to the preliminary conclusion by CMS. The Hospital had *no* opportunity to litigate any issue, or to defend itself in any way, at any point while the matter was before CMS. In applying *U.S. v. Utah Construction*, the Eleventh Circuit has cogently explained why the type of "finding" at issue here cannot be given preclusive effect:

> The doctrine of res judicata has been applied in the administrative context. An administrative decision will be given res judicata effect when "an administrative agency is acting in a judicial capacity and resolves disputed issues of fact properly before it which the parties have had an adequate opportunity to litigate. . . ." *United States v. Utah Construction and Mining Co.*, 384 U.S. 394, 422, 86 S.Ct. 1545, 1560, 16 L.Ed.2d 642 (1966). *See Pantex Towing Corp. v. Glidewell*, 763 F.2d 1241, 1245 (11th Cir. 1985). The administrative decision approved by the Supreme Court in *Utah Construction, supra*, was the result of a full adversary proceeding with testimony, cross-examination, exhibits, briefs, and argument. *See Nasem v. Brown*, 595 F.2d 801, 807 (D.C. Cir. 1979). *It follows that an agency proceeding which does not afford an opportunity to*

> *present live witnesses or to cross-examine opposing witnesses does not meet the test that the parties were afforded a full opportunity to litigate. Nasem v. Brown*, 595 F.2d at 807. *See* 4K. Davis, Administrative Law Treatise, § 21.4 (2d ed. 1983).

City of Pompano Beach v. Federal Aviation Administration, 774 F.2d 1529, 1539, n.10 (11th Cir. 1985) (emphasis added).

Still another requirement for collateral estoppel also is not satisfied here, because the issues to be estopped were not "actually litigated and determined" in the administrative proceeding. *Pantex Towing*, 763 F.2d at 1245. As discussed above, the question whether Dulan could recover under EMTALA was not even the same issue decided by CMS, and the issue on which CMS did reach a conclusion was not "litigated" at all. Dulan's collateral estoppel argument is directly contrary to applicable law, as the District Court correctly concluded.

Finally, whether the CMS conclusion should have been given preclusive effect is a moot point, because Dulan could not have recovered on her EMTALA claim even if the CMS conclusion had been binding on the court. As noted above, the EMTALA provision authorizing a private right of action permits a recovery by an individual who "suffers personal harm" as a result of a violation of the statute. 42 U.S.C. § 1395dd(d)(2)(A). In the absence of personal harm directly resulting from an EMTALA violation, there is no cause of action. *See, e.g., Vargas v. Del Puerto Hospital*, 98 F.3d 1202, 1205 (9th Cir. 1996). As the District Court observed, Dulan presented no evidence, much less competent medical testimony, to establish that she was harmed in any way by any alleged delay in providing care or treatment. In the absence of such evidence, she could have no valid claim under EMTALA.

III. Federal law, not Alabama law, controlled the decision whether to strike Dulan's expert for noncompliance with the scheduling order.

Dulan also contends the District Court failed to follow *Erie Railroad Company v. Tompkins*, 304 U.S. 64, 58 S.Ct. 817 (1938), in "disregarding" Alabama's doctrine of equitable estoppel when determining whether to strike Dulan's medical expert due to noncompliance with the court's scheduling order. The decision to strike the expert actually was controlled by federal law, which was correctly applied by the District Court.

The scheduling order could be modified only for "good cause," FED. R. CIV. P. 16(b), and this "good cause" standard "precludes modification unless the schedule cannot 'be met despite the diligence of the party seeking the extension.' " *Sosa v. Airprint Systems, Inc.*, 133 F.3d 1417, 1418 (11th Cir. 1998) (citation omitted). After Dulan failed to meet the scheduling order's deadline for designating an expert, and failed to timely request an extension of the deadline, the District Court concluded there was no good cause for modifying the scheduling order. That decision was well within the court's discretion.

This argument by Dulan again raises a moot point, because the Hospital and Dr. Andershock would have been entitled to a summary judgment even if the court had modified the scheduling order to allow the tardy expert designation. The expert was a cardiologist and not a board certified emergency physician like Dr. Andershock, the physician who allegedly breached the standard of care. Under Alabama law, which governed Dulan's medical malpractice claims, the expert was not qualified to offer an opinion that Dr. Andershock breached the standard of care, because the expert was not "similarly situated" to Dr. Andershock under the Alabama statute that specifies the qualifications medical experts must possess.

See Ala. Code § 6-5-548 (1975). Since Dulan's designated expert could not have provided the testimony needed to support Dulan's medical malpractice claims, any error in striking the expert was harmless.

IV. The summary judgment on the state law medical malpractice claims was appropriate.

Dulan also contends the Court should review the summary judgment entered on her medical malpractice claims because the District Court supposedly violated *Erie* by failing to apply pertinent Alabama case law. Specifically, Dulan argues she was not required to support her medical malpractice claims with the testimony of her own expert, because Alabama law recognizes that the applicable standard of care can sometimes be established b the introduction of a "recognized standard or authoritative medical text or treatise." *See, e.g., Tuck v. Health Care Authority of the City of Huntsville d/b/a Huntsville Hospital*, 851 So.2d 498, 506 (Ala. 2002). Like Dulan's other arguments, this argument is both incorrect and addressed to a moot point.

Although Dulan contends that certain guidelines published by the American College of Cardiology and the American Heart Association established the standard of care Dr. Andershock was required to follow, there was no expert testimony that the guidelines were the standard of care. Dr. Andershock briefly referenced the guidelines in answering a question at his deposition, but he did not testify that a deviation from the guidelines was a breach of the standard of care. (Doc. 97, Ex. 9, p. 39). Moreover, even if Dulan had proven that the guidelines set the standard of care and that Dr. Andershock deviated from the guidelines, she still could not prevail on her medical malpractice claims without presenting the testimony of a qualified medical expert to establish that a breach of the standard

of care proximately caused an injury. *See, e.g., Sorrell v. King*, 946 So.2d 854, 862 (Ala. 2006). Dulan presented no such testimony, and the summary judgment on the medical malpractice claims was appropriate for that reason alone.

CONCLUSION

For the reasons discussed above, the petition for certiorari should be denied.

Respectfully submitted,

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